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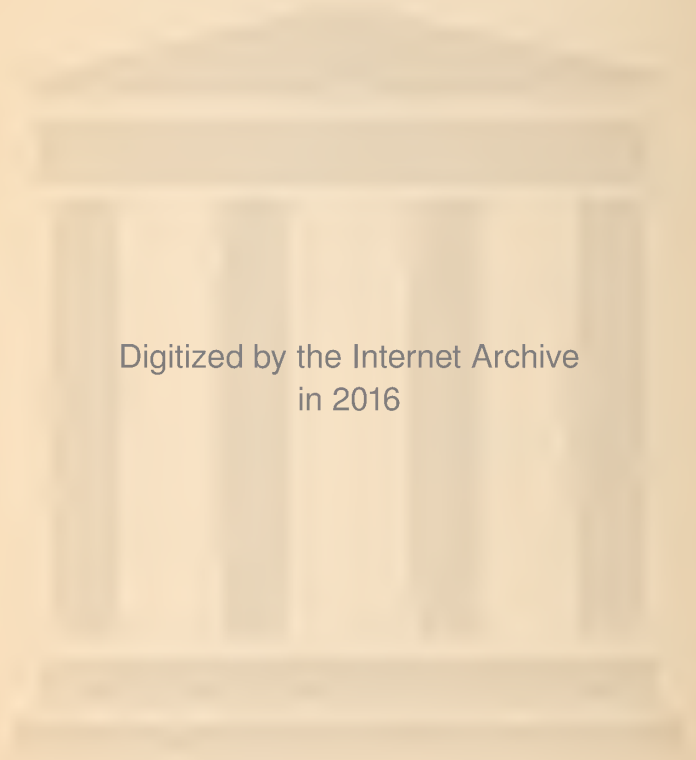

HELPING BEHAVIOR AS A FUNCTION OF STAFF AND PATIENT ROLES IN PSYCHOTHERAPY GROUPS: A PILOT STUDY*

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The purpose of this paper is to report on the development of an observational technique for the assessment of group psychotherapy. The research was designed to investigate the helping role in a preliminary pilot study with therapy groups at Fort Logan Mental Health Center.

There are several observational systems available for studying groups, the best known of these being Bales' Interaction Process Analysis (1). For example, Strupp (5,6,7) has found Bales' category system useful for comparing the techniques used by therapists of different orientations in responding to an experimental series of patient statements. Some researchers, however, have found the Bales' system insufficient for analyzing interactions in group psychotherapy (3). One reason for this seems to be that the Bales' categories were developed for use primarily with small work groups oriented toward accomplishing specific tasks. In group therapy, the task is a general one of helping others get well. The problem for the researcher interested in studying group psychotherapy would seem to be to describe those activities of group members which count as instances of helping others to get well.

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There are numerous activities that one might count as helpful in the course of group psychotherapy. Yet, to successfully approach a more complete description of psychotherapy, it would seen necessary to map out systematically the possible means (i.e., techniques) that could be used to achieve success in therapy (i.e., help someone). Given the ability to describe helping behavior in group psychotherapy, another goal might be to study other factors such as personality, training, and social structure that would influence the practice of helping behavior in therapy groups. Once a good description of the means people use to help others is available, one can envision the possibility of cataloguing the various means-end relationships in such a way that it may be determined which means are most effective in achieving which ends (cf. Ossorio, 1966, for some general principles and basic formulations appropriate for such a means-end analysis).

The present research is neither a means-end study nor an outcome study of group psychotherapy. It is an observational study of a few of the helping activities engaged in by members of groups and an attempt to relate the performance of helping activities to a social structural variable--role differentiation.

The influence of social structural variables on group therapy is important for several reasons. First of all, almost any contemporary social psychological treatise on groups emphasizes the differences that various social structural variables--norms, roles, power structure, social stratification, and so on--make in the practices and activities engaged in by the members of a group. What sorts of social structural variables are important for the difference they make regarding the manner in which group therapy is performed? Secondly, can such variables be isolated and manipulated to bring about more effective group therapy? Finally, another reason why such variables are of particular interest here is that one of the goals of the institution under study has been to abolish the traditional mental hospital role hierarchies (both among and between staff and patients) and, by minimizing role differentiation, to create a more therapeutic environment (2). It, then, becomes important to investigate what kinds of differences exist in roles in the therapeutic community. The study of the relationship

between helping behavior and role differentiation is only one of the ways to investigate such issues.

In an institution that sets as its task the helping of patients, it would be reasonable to expect that role differentiation would manifest itself in terms of the different sorts of helping activities engaged in by people occupying different roles. Thus, one aim of this research was to study the relationship of helping behavior to the various statuses and role positions in the various therapy groups. The above notions can be summarized in the form of three hypotheses:

1) The social structure of the therapy groups under study is such that patient and staff roles can be distinguished by the sorts of helping activities engaged in. More specifically, the staff, due to its psychiatric training and leadership functions, tends to make more probing questions and more interpretative statements than the patients. The patients tend to make more supportive remarks and more suggestions.

2) The staff engages in different helping behaviors depending on its position in the social structure role heirarchy (psychiatrist and psychologist as compared to nurse, psychiatric technician, occupational therapist and recreational therapist).*

3) If there are differences in the social structural formations of the various teams observed, then, such differences ought to be manifested in terms of differences in helping activities. Such social structural differences will be assumed; and, therefore, it is hypothesized that there are significant differences in the helping categories used by different teams.

METHOD

Observational Assessment Procedures

Since the aim of this research was not to exhaust the

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*Psychiatrists and psychologists will be referred to as team leaders; nurses, psychiatric technicians, occupational therapists, and recreational therapists will be referred to as assistant team leaders.

possibilities of helpful behavior, a small number of behaviors which (1) seemed easily identifiable and (2) were the sorts of behaviors in which people could reasonably be expected to engage during the course of group psychotherapy were chosen. A description of the five verbal behaviors chosen follows:

1) *Supportive Remarks:* any positive reinforcement directed toward another person, such as "I agree with what you are saying," "You look nice today."

2) *Probing Questions;* questions of a therapeutic nature, such as "How do you feel about that?" "What happened next?" Questions aimed at getting specific information not related to helping or questions about task structure (e.g., "What do we do tomorrow?") were not coded here.

3) *Suggestive Statements:* any advice-giving or direct suggestions, e.g., "Why don't you...?" "How about trying this?"

4) *Interpretative Remarks:* any statements that involve offering an explanation for another's behavior, e.g., "It seems that you did this because...," "But weren't you really doing this?"

5) *Reflective Statements:* in the Rogerian sense, any restatement of what another person has been saying, e.g., "You mean...?" "It sounds like you're saying...?"

Any statement by any member of a group that could be coded into one of the above five categories was so coded if the intent of the person making the remark appeared to be one of helping; a hostile, sarcastic remark that had the form of an interpretative statement would not be coded. Thus, the only judgments made by the observers about the helpfulness of a remark were whether or not the person making the remark *intended* to be helpful. Whether or not the remark was, in fact, helpful was a question we did not attempt to answer. The relative frequency of the five types of helping behavior also was coded in terms of who made the statements and to whom the behavior was directed. In addition to the categories, the total number of communications per 15-minute time period were counted. It was thought that some groups would be more active verbally than others and that this factor should be taken into account in comparing the helping behaviors found in the different groups. Ratio figures--helping behavior observed/number

of communications--were computed for each 15 minutes of observation as a control for differences in activity levels over time and groups.

Subjects

The subjects for this study consisted of the members of three ongoing psychotherapy groups at the Fort Logan Mental Health Center. The first group, Team A, consisted of 13 patients and 4 staff members. The second group, Team B, had 15 patients and 3 staff members. The third therapy group, Team C, at the time of the present observations, consisted of 16 patients and 8 staff members. Thus, a total of 44 patients and 15 staff members were observed. Approximately 60% of the patients were day patients and the remaining 40% were inpatients. The staff observed consisted of psychiatrists, psychologists, psychiatric nurses, psychiatric technicians, occupational therapists, and recreational therapists.

Reliability

Two observers familiarized themselves with the categories by observing four one-hour simulated group therapy sessions with college subjects. The interjudge percentage agreement across all categories began low (55%) but increased markedly as the training sessions progressed (78% agreement by the fourth session).

At Fort Logan, the same two observers (making independent but simultaneous ratings) sat in on one 50-minute session from each of the three different therapy groups. The two observers used the first five minutes of each of the three sessions for numbering the various members of the group so that "who to whom" could also be coded. The next 45 minutes of each of the three different sessions were divided into three periods of 15 minutes each. As there were three 15-minute periods for each therapy group, the total N observed was nine.

As can be seen from Table 1, the interjudge percentage agreement ranged from 58.0% on suggestions to 85.0% on probing questions. The total percentage agreement across all categories, teams, and time intervals was 81.3%. Note also that the observers' skill increased over time, percentage agreement figures being in the lower 70's for the first team observed (A), upper 70's and lower 80's for the second team (B), and upper 80's for the third team (C).

TABLE 1

PERCENTAGE AGREEMENT BETWEEN TWO RATERS ACROSS DIFFERENT CATEGORIES AND TEAMS

TEAM	SUPPORT.	QUEST.	SUGGEST.	INTERP.	REFLECT.
A	10/13	90/109	6/10	64/73	6/9
B	10/12	102/114	10/13	64/70	8/11
C	4/8	52/64	2/8	48/70	4/6
Tot	24/33	244/287	18/31	176/213	18/26
% Agree	72.7%	85.0%	58.0%	82.6%	69.2%

RESULTS

It was hypothesized that staff and patients differ significantly in the amount of helping behavior relative to the total amount of communications, across all categories and across all teams for all time intervals (see Table 1A and Table 1B). This expectation was confirmed ($t = 2.94$, $df = 16$, $p < .005$). It was further hypothesized that patients and staff differ in amount of helping statements, relative to total helping across all teams and categories over *all* time intervals (Table 2A). This hypothesis was also confirmed at the $p < .001$ level (Table 2B).

(See Tables 1A, 1B, 2A and 2B on pages 103 and 104)

TABLE 1A

SUMMARY TABLE: RATIOS OF STAFF AND PATIENT HELPING BEHAVIORS TO TOTAL COMMUNICATIONS BY TEAM AND BY 15 MINUTE INTERVALS (MUTUALLY AGREED UPON RATINGS)

Team	# Staff Helping Comments/ # Total Communications	# Patient Helping Comments/ # Total Communications
Team A*	21/57	7/57
	18/58	8/58
	22/60	10/60
Team B**	16/76	19/76
	16/85	20/85
	17/65	10/65
Team C***	9/55	9/55
	17/55	5/55
	8/25	7/25

* Team A had 13 patients and 4 staff members.
** Team B had 15 patients and 3 staff members.
*** Team C had 16 patients and 8 staff members.

TABLE 1B

STAFF HELPING/TOTAL COMMUNICATIONS VS. PATIENT HELPING/TOTAL COMMUNICATIONS

	Mean	Variance	t-Test
Staff	.277	.005	2.94*
Patients	.177	.004	

*$p < .005$

TABLE 2A

RATIOS OF STAFF AND PATIENT HELPING/TOTAL HELPING

Team and Interval	# Staff Helping/ Total Helping	# Patient Helping/ Total Helping
Team A_1	21/28	7/28
Team A_2	18/26	8/26
Team A_3	22/32	10/32
Team B_1	16/35	19/35
Team B_2	16/36	20/36
Team B_3	17/27	10/27
Team C_1	9/18	9/18
Team C_2	17/22	5/22
Team C_3	8/15	7/15

TABLE 2B

STAFF HELPING/TOTAL HELPING VS.
PATIENT HELPING/TOTAL HELPING

	Mean	Variance	t-Test
Staff	.609	.013	4.05*
Patients	.309	.012	

*$p < .001$

In sum, the staff contributed more helping behavior, as coded by our rating scale, than did patients relative to both total amount of communication and total amount of helping. Since this is controlled for activity level, and does not merely mean that the staff "talked more," these results indicate the extent of staff leadership in the three teams sampled at Fort Logan.

In order to determine whether or not there were significant differences between staff and patients in the different categories of helping behavior, *t*-tests were made upon the ratios of staff helping over total helping *compared to* patient helping over total helping, for each category, over all teams, for all 15-minute time intervals. The results (Table 3) support the hypothesis that the staff uses more probing questions ($t = 5.03$, $df = 16$, $p < .001$) alalthough its complement, that the staff is also more interpretative, only tends toward significance at the $p = .10$ level. For the patients, the hypothesis that they use more suggestions than the staff only tends toward significance ($t = 1.54$, $p < .10$); the complement, that the patients are also more supportive, is not significant but is in the predicted direction. The only significant difference between staff and patients was in the category of probing questions.

(See Table 3 on page 106)

TABLE 3

TESTS: STAFF HELPING/TOTAL HELPING VS. PATIENT HELPING, BY CATEGORIES

Categories		Mean	Variance	t-Test
Supportive	Staff	.018	.0007	.857 NS
	Patient	.030	.0009	
Questions	Staff	.338	.0080	5.03*
	Patient	.167	.0007	
Suggestions	Staff	.007	.0002	1.62[1]
	Patient	.029	.0014	
Interpretations	Staff	.226	.0098	1.54[1]
	Patient	.152	.0087	
Reflections	Staff	.020	.0004	.278 NS
	Patient	.017	.0004	

* $p < .001$.

[1] Approaches significance at $p < .10$.

Another area of investigation was the hypothesized differences between assistant team leaders (i.e., nurses, psychiatric technicians, occupational therapists and recreational therapists) and team leaders (i.e., psychiatrists and psychologists) in terms of their relative engagement in the different types of helping behavior. It was decided to test by chi-square the team leaders versus assistant team leaders according to three categories of helping behavior (Table 4).*

*Because of the insufficient number of observations in certain cells of the total matrix of team leader/assistant team leader by the five categories, the matrix was collapsed as follows: Suggestions were omitted (only two team leader observations) and the category of Reflections (two team leader, four assistant team leader) was combined with that of Supportive (three assistant team leader observations only).

TABLE 4

STAFF BY CATEGORY INTERACTION

	Team Leaders	Assistant Team Leaders	Totals
Supportive & Reflective	2	7	9
Probing Questions	58	25	83
Interpretative Remarks	33	19	52
Totals	93	51	144

The obtained chi-square value of 8.05 shows a significant category interaction ($p < .025$). By inspection of the table, it can be seen that the team leaders exhibited more Probing Questions and Interpretations, while the assistant team leaders exhibited more Supportive and Reflective remarks.

It was also hypothesized that the three teams differ in the frequency with which they engage in the five different helping behaviors. Table 5 shows the relative frequency of helpful behavior for the five categories by team. The frequencies for the different 15-minute intervals were summed and the amount of communication was controlled by taking a ratio (helping/number of communications in any given 15-minute interval). It was decided to test the third hypothesis of differences in teams by categories of helping behavior through a one-way analysis of variance across the three teams for each of the five categories. The results obtained by this method are presented in Table 6. There were no significant F ratios, and the hypothesis of differences between teams by categories could not be upheld.

TABLE 5

AMOUNT OF HELPING BY CATEGORY FOR EACH TEAM

	Support.	Quest.	Suggest.	Interp.	Reflect.	Totals
Team A	86	757	52	544	51	1490
Team B	61	689	70	428	52	1300
Team C	58	582	18	633	36	1327
Totals	205	2028	140	1605	139	4117

TABLE 6

FIVE ONE-WAY ANOVA'S--THREE TEAMS
BY FIVE CATEGORIES

Variable	Source	*df*	MS	F Ratio
Supportive Remark	Between groups	2	78.78	.283
	Within groups	6	278	
Probing Questions	Between groups	2	2594.34	2.714
	Within groups	6	955.89	
Suggestive Statements	Between groups	2	232.44	.739
	Within groups	6	314.55	
Interpretative Remarks	Between groups	2	3522.33	.365
	Within groups	6	9642.55	
Reflective Statements	Between groups	2	26.78	.186
	Within groups	6	143.78	

Note: With *df* 2, 6, F ratio of 5.14 is needed for significance at $p = .05$.

DISCUSSION

The first two hypothesis concerned the relationship of helping behavior to role differentiation. It was thought that one pervasive aspect of the social structure of the institution would be the extent of role differentiation found in the therapy groups.

Furthermore, it was thought that this would manifest itself in the different forms of helping behavior exhibited by the occupants of different roles.

To test the first hypothesis, the differences between the role of staff and the role of patient were investigated. First, it was found that the staff engaged in significantly more helping behavior over all categories than the patients did. Secondly, when broken down by category, the only significant difference was that the staff made more probing questions than the patients. Although the staff also made more interpretations and the patients made more suggestions and supportive remarks, these differences were not significant. Although the differences obtained between staff and patients were not as large as expected, they were all in the predicted direction. Furthermore, the fact that some of these expected differences were not significant may suggest that Fort Logan has succeeded in doing away with some of the differences usually found in patient versus staff roles. Yet, in terms of the concepts of training and expertise, it seems reasonable to find the staff asking more questions and tending to make more interpretations. However, the patients, by virtue of the fact they are patients, are not expected to be highly visible in the helping role. Therefore, when they do help, they tend to do it by engaging in activities that are more facilitative rather than directive; namely by making suggestions and occasionally supportive remarks to other patients.

The second hypothesis concerned the differences between the various roles the staff occupied. The staff was divided into two groups based on the amount of training and assumed status differences. The first group, the team leaders, made more interpretative remarks and asked more probing questions than the second group, the assistant team leaders. In addition, the assistant team leaders tended to be more supportive and reflective than the team leaders. Although no statistical test on the magnitude of these *specific* differences was made,* a chi-square test for

*However, there is little question about the interpretation of these differences when we consider both their magnitude (Interpretations 33 vs. 19; Probing Questions 58 vs. 25; Supportive and Reflective remarks 2 vs. 7) and the fact that such differences were obtained with only *three* team leaders contributing—one on each of the teams.

independence showed a significant interaction between the categories and the team leader-assistant team leader staff breakdown. It is possible to interpret this finding in several ways. First of all, given that the psychologists and psychiatrists do occupy high status positions and since all were designated leaders of their respective therapy groups, more visible or salient helping behaviors by the team leaders (i.e., interpretations and probing questions) and less visible or salient helping behaviors by the assistant team leaders (i.e., supportive and reflective remarks) might be expected. Secondly, it is possible that the training experiences of the two groups contributed to these differences. For instance, it is quite probable that the team leaders (the psychiatrists and psychologists) were trained in the use of dynamic, psychoanalytically-oriented techniques which employ interpretations and probing questions. Furthermore, it is a fair guess that the assistant team leaders (nurses and psychiatric technicians comprised more of the sample here) were trained most in nondynamically oriented, nondirective therapeutic techniques, such as reflecting on patient feeling and making supportive remarks. Finally, it is worth noting the similarity between the present data and that of Strupp (5). Although Strupp (5) did not use an actual therapy situation, the assistant team leaders in the present study were most like his sample of Rogerian therapists, while the team leaders were most like Strupp's psychoanalytically oriented therapists.

Under the third hypothesis, it was predicted that there is a difference in the various teams observed according to their relative use of the five helping categories. It was thought that if there were differences among teams in such things as power structure, spontaneity of communications, cohesiveness, and so on, these differences would appear also in the relative use of the various helping behaviors. However, team-by-category analyses were not significant and, thus, the null hypothesis of no difference between teams could not be rejected. Yet, if such differences in social structure variables do exist among different teams (and, we assume they do--unless the social structure of the institution is completely pervasive), it can be argued that given a larger sample

of different therapy groups over a greater number of sessions, such differences would have revealed themselves in helping behavior. That is to say, differences in social structure ought to be manifested in how the members of a group go about performing the group's task--and, the task of a therapy group is one of helping the members of that group. The data of the present study show that the three therapy groups observed were not as different as one might expect them to be.

Turning to more global concerns, the variable of helping behavior should have relevance to settings or situations in the mental health hospital other than the therapeutic group. We would expect helping behavior to occur in most of the interpersonal activities and that such behavior could be assessed by the categories (or a refined version of them) devised for this study. Among the possible areas of concern, it would seem that other group interactions such as pass-and-privilege sessions or psychodrama would be most relevant. The nature, extent and differentiation of helping should vary somewhat depending upon the given situation. For example, if some of the teams utilize what are known as "alternative sessions," in which the patients meet as a group but *without* any staff member present, there should be less status differentiation and a greater diffusion of the leadership role. This diffusion might be expressed in terms of the categories as a decrease in probing questions and/or interpretations, (if these are indeed largely a function of the "official" leader or other staff members) with a proportionate increase in the give-and-take of supportive and reflective interchanges. A similar analysis could be performed upon any of the other group settings or situations.

Another relevant area, aside from role differentiation, is the consideration of group cohesiveness and member satisfaction, which might be manifestations of more effective helping. In order to examine this relationship, an increase in the number of teams observed and an increase in the longitudinal duration of observation would be essential.

The assessment of the extent and differentiation of helping behavior in the therapeutic setting has a logical application in the evaluation of what is "good," "efficient," or "successful"

treatment. This pragmatic concern is far from realized in the limited pilot study presented; however, it may be assumed that such assessments could profoundly affect the establishment and utilization of therapy groups and the training of group therapists. The ultimate means-end study would go beyond the mechanics of group structure and function and would attempt to relate the different patterns of helping to some criteria of successful treatment. This, again, is a matter for future research with refined instruments and larger samples of observation.

SUMMARY

An observational technique was utilized to study the relationship of helping behavior to role differentiation in ongoing psychotherapy groups. The categories of helping behavior chosen for assessment purposes were: Supportive remarks, Probing questions, Suggestive statements, Interpretative remarks, and Reflective statements. It was found that staff members engaged in more helping behaviors than patients (controlling for overall activity level). Yet, the only major difference in specific helping behaviors was that the staff used probing questions significantly more than the patients did. Team leaders (psychologists and psychiatrists) tended to ask more probing questions and offer more interpretations than other therapists. Nurses and psychiatric technicians, however, tended to make more supportive and reflective remarks than team leaders did. There were no significant differences in the relative use of the various categories of helping behaviors in the three therapy groups observed.

As only three therapy groups were observed for one session each, the above results can only be tentative. However, it is the authors' view that the kind of observational techniques employed here demonstrate their applicability to research on group psychotherapy. Further work along these lines would constitute a worthwhile research task.

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THE TEAM AND THE CONCEPT OF DEMOCRACY*

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INTRODUCTION

At Fort Logan, the basic work group for accomplishing the aims of the Center is the team. The clinical team ordinarily consists of a psychiatrist, who is the team's leader, a psychologist, two social workers, seven nurses, seven psychiatric technicians, and a ward clerk. Additional personnel such as recreational and occupational therapists and a vocational counsellor may be attached part time to the team. In the adult psychiatric division, the team has primary responsibility for treating all patients coming from its geographic catchment area. Each team has from 60 to 100 patients in a variety of modes of partial or full hospitalization. Usually, when the word "team" is used, it is the clinical team which is meant. This discussion will have primary reference to the clinical team, although most of it could also apply to such nonclinical teams as administration and research.

In the development of a team, a great deal of stress is placed on the team functioning in a democratic way rather than in an authoritarian or autocratic manner. It is the purpose of this paper to examine the concept of democracy in terms of the functioning of a team. The thesis of the paper is that the concept of democracy has a strictly limited relevance to team functioning, that it has been largely misused, and has caused a good deal of unnecessary conflict. It is hoped that, by examining and clarifying this key concept, the benefits of democratic ways of functioning may be realized without the disruptive internal battles that arise

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from the lack of clarity as to the concept's meaning and implications.

THE MEANINGS OF DEMOCRACY

A good first step for discussing the implications of the term "democracy" for team functioning is a brief look at the various meanings of the term. *Webster's New Collegiate Dictionary*, 1960, lists four meanings. They are essentially as follows: 1. *Government by the people; government in which the supreme power is retained by the people and exercised either directly (absolute or pure, democracy), or indirectly (representative democracy) through a system of representation;* 2. *A community or state so governed;* 3. *United States--the principles and policy of the Democratic party; also, that party, or its members;* 4. *Belief in or practice of social equality; absence of snobbery.*

It seems clear that for the purposes of this discussion we need only concern ourselves with the first definition which relates to political democracy, and the last one which concerns social democracy. However, there is another key word to consider at this point, "snobbery." Again, using the same *Webster's New Collegiate Dictionary*, we find that snobbery is defined as "snobbish conduct; snobbishness." Snobbish, in turn, is defined as "characteristic of, or befitting a snob." Therefore, we need turn to the various meanings of the word "snob:" 1. *One who blatantly imitates, fawningly admires, or vulgarly seeks association with those whom he regards as his superiors;* 2. *One, who by his conduct, makes evident that he sets excessive store by rank, wealth, and social eminence, to the detriment of merit;* 3. *One who repels the advances of those whom he regards as his inferiors; as an intellectual snob.*

Here the key definition seems to be the second, which stresses that snobbery consists of valuing rank more than merit. Translating it into our situation a little more closely, it means being more concerned with who says something than with what is said.

THE TEAM AND POLITICAL DEMOCRACY

In political democracy there is a time-limited transfer of specified powers from those who are to be governed to those who will govern. There may be considerable variation in the mechanics of achieving this transfer and in the sorts of powers transferred, but the power to create governing force remains vested in the people who are governed.

In considering the structure of a team, it is clear that the formal governing power of the team leader does not derive from a transfer of powers from the team members. By "formal power," I mean those rights he has been given by the rules and regulations of the organization. These formal powers to run the team were given to him by a higher authority within the structure of the organization. In this strictly limited sense, the formal power of the team leader does not depend on whether the team members agree with his decisions, like them, or even understand them. On the other hand, the informal power of the team leader may be greatly affected by these latter considerations. By "informal power," I mean the leader's ability to get his team members to perform their various tasks in the most effective way possible. The minute we consider informal power, however, we have gotten away from the political definition of democracy, the formal exchange of power, and have entered the realm of social democracy, which concerns itself with a system of interpersonal beliefs and attitudes.

THE TEAM AND SOCIAL DEMOCRACY

Social democracy, the primary concern with social equality or the merit of what a person may say or do rather than with his status, seems to have a familiar ring to it. It seems very much related to the role sharing, blurring, or diffusion we have talked about so much. It seems related to the idea that all members of the team may be able to make valuable contributions to the treatment of a given patient, and that the value of these actions may not be

closely related to their position in the pecking order on the team. Thus, we do find ourselves practicing some form of democracy; however, what we do may have more to do with social democracy than with political democracy. The distinction is an important one. If we use political democracy as our model, there is a tendency to think of each individual as having an equal voice in the decisions of the team, a sort of "one person, one vote" model. Or, putting it another way, "I empowered you to act the way I vote," model.

Social democracy, on the other hand, tends to equalize not everyone's influence on the decisions to be made, but everyone's right to express an opinion on these decisions. That is, it is assumed that anyone working on a team may have something relevant to say on a given matter. Paradoxically, this should lead not to equalization, but to marked differences in each one's influence if we assume that different people will produce ideas of different merit. If these same ideas were not offered in an atmosphere of social democracy, they would be judged not on their merit but on the position or rank of the individual offering them. While we may not attain the situation in which each idea is judged solely on its merit, even an imperfect attainment of this goal should be an improvement over judging ideas by the rank or status of the originator.

THE TEAM AND THE SOCIAL DEMOCRATIC IDEAL--LIMITING CONSIDERATIONS

Even if we can agree that the social structure of a team should attempt to approximate a social democracy, how it might best attain this ideal is still another question. Further, we must remember that the team's *raison d'etre* is not to give team members a chance to experience social democracy--the team exists as the primary work unit of the Center. The work of the Center is to provide the best possible treatment resource for a given population of individuals--some who seek help from it directly and some who are benefitted indirectly. Given this ideal, then, certain limitations seem inherent in trying to attain it.

Time is the first limiting factor in attaining a pure social

democracy. It takes time to consult everyone on every question. Even in a very small group, consultation may be impossible. As the group grows larger, fewer and fewer questions can be submitted to it for consideration. Just as the driver of a fast-moving car may not consult his passenger when he has to make a sudden choice of routes, so the individual team member cannot consult every other team member on every decision during the course of a day. This may be summed up by saying, "You can't gripe simply because something was decided and you were not consulted." This is not sufficient ground. Just as it takes time to find out what others think, it takes time to give them the information upon which to base an informal opinion. If certain crucial bits of information are not available to the team member, the usefulness of an otherwise competent opinion may be severely limited. The leader's task is to decide whether or not he has the time or the inclination to make available the missing information. If he does not make it available, he must keep the final decision for himself. Such a solution may become a destructive rationalization for keeping all decisions for himself, because he, and only he, sees the "whole picture." It avoids effective use of the critical powers of the group to see if they, too, would reach the same conclusion in the light of the "whole picture."

Interest is a second limiting factor. Much as people like to be consulted on things, you will find them more interested in giving opinions on some questions than on others. Lack of interest may be due to a felt lack of competence on a question, such as technical questions in engineering, accounting or dietary problems, or it may be due to the feeling that the decision can be made satisfactorily without consultation. The latter is generally true of the thousands of details in the operation of any complex organization. There are times when, initially, the person consulted is not interested in giving an opinion and then wakes up to the fact that he is violently opposed to the decision made. Therefore, it is important not only to gauge whether or not a person is interested, but also whether he *should be* interested in helping with a certain decision. The wise leader will attempt to motivate a team member to be interested in any decision which ultimately will concern that member.

A third limiting factor is competence. While it is within the social democratic ideal that everyone should feel free to voice an opinion, the merit of the opinion will vary with the background, experience, and opportunity to make relevant observations. Consequently, when opinions for a decision are sought, it makes sense to seek those that are likely to have the greatest merit. However, it is not the right, but the duty of an individual working on a democratically run team to offer his observations and opinions, especially if they run counter to the decisions being reached. The distinction between a right and a duty is important here. Working in a socially democratic atmosphere makes demands on the team members as well as the team leader. If speaking up were simply a right, the person could exercise it as he saw fit. A duty, however, implies that he must speak up if he has something relevant to say. The team leader should be free to assume that if he hears no dissenting opinions, there are none. This is an idealized situation, but one the team should strive to approximate.

A fourth limiting factor is the type of decision to be reached: (a) on a question of fact, (b) on a question of consensus, or (c) on a question of the most probable course. When the issue is a question of fact, the democratic process is irrelevant. There may be a variety of opinions as to what the facts are, but the problem is essentially that of identifying the most reliable source of the desired factual information.

The democratic process can be an effective tool for arriving at a valid consensus. In effect, the participants are told not only that they should have an opinion on the matter, but that they must be willing to live with that opinion, if it turns out to be the majority one. This is especially appropriate in situations in which there are a number of acceptable alternatives at hand, and the one that will work the best is the one with the greatest group support.

Questions on finding the most probable course of action are the most difficult ones. These usually involve situations which are so complex that all the facts cannot be known, although success or failure will depend largely on a correct assessment of the unknowns. Whether the unknowns are primarily questions of fact or questions of consensus may determine whether or not the democratic process is appropriate.

A fifth limiting condition concerns the degree to which a decision will involve the participant. Even given sufficient time, interest, and competence, it may not be appropriate to involve someone in a decision which does not affect him. While there may be special circumstances in which this is the ideal type of person to involve, the team leader would be well advised to give primary consideration to consulting team members who will be affected in important ways.

In summary, there are at least five major limiting factors that would tend to prevent attainment of an ideal socially democratic work atmosphere: (a) the amount of time available; (b) the interest of the participants; (c) the competence of the participants; (d) the type of decision to be reached; and (e) the involvement of the participant. The freedom to express one's opinion on issues is not only a right, but a duty in a socially democratic atmosphere. It is the needed contribution to the work of the group, rather than the sanction needed by someone with the proper formal powers to make a decision or take an action. The latter might be true in a political democracy, especially if there were a limited transfer of powers from the governed to those who govern.

THE TEAM AND THE SOCIALLY DEMOCRATIC IDEAL--POSITIVE CONSIDERATIONS

In view of the seemingly inherent limitations in attaining a pure social democracy one might wonder, "Why bother?" The answer is that a socially democratic work atmosphere also has a number of inherently powerful advantages over a more authoritarian or autocratic system:

1. It tends to enable each individual to maximize his contribution to the team's functioning. Each individual is encouraged to exercise his ability to evaluate actions, make decisions, and find new solutions to problems. Team members are not expected to function simply as blind tools carrying out the team leader's instructions, but are expected to fulfill the spirit rather than the letter of those instructions.

2. Through the decentralization of the decision-making function, many decisions can be made by personnel at the time questions arise. This means decisions can be more timely and can be guided by relevant considerations that arise concomitant with the questions. This does not imply the team leader's abdication of responsibility or of the right to review those decisions. He can still question whether the decisions are helping to attain the goals of the team, i.e., whether they were "good decisions." In general, however, he would not question the right of the individual to have made the decision.

In contrast, the individual's right to make decisions would be circumscribed in an authoritarian structure. A decision outside of these narrow boundaries would be sufficient grounds for criticism, and the fact that it was a "good" decision might or might not help the individual's cause.

3. Along with decentralization of decision-making functions, there is also a decentralization of control functions. That is, the individual performs his task in a certain way because he believes it is the right way and not because someone will check to see how it was done. Again, the team leader does not abdicate the control function, but he should be able to devote fewer resources to it than under a system in which the individuals are doing as he wishes only because they have been ordered to do so.

4. The socially democratic model involves team members in the work of the team by actively seeking their advice and counsel. The fact that their opinions frequently have an impact on the way the team functions is a reinforcing experience. This generally leads to the team members giving greater effort to their work and in their achieving greater work satisfaction than if they had no voice in how things were done.

5. The socially democratic model, more than the authoritarian model, tends to encourage more open feedback of information to the team leader. There is more tendency on the part of team members to say what they think than to say what they are expected to think. Since the ability of individuals to deceive themselves is known to be considerable, the encouragement of this constant, open reality-testing function may be the most valuable attribute of the democratic model.

DEMOCRACY AND RESPONSIBILITY

In sharing decisions, it is often easy to become confused about who is responsible for these decisions. We have already seen that the team leader's responsibility was derived not from a political transfer of powers from the team, but from a higher authority within the Center power structure. The team leader's decision to encourage a socially democratic atmosphere on his team is not a way of abdicating his responsibility, but a way of exercising it. He could also exercise this responsibility by trying to do all the tasks of the team himself or by ordering team members to do only those tasks which he had specifically told them to do. In any case, the evaluation of how well he meets his responsibilities should be based on how well his team fulfills its goals of providing a treatment resource, not on whether he did a specific task himself. The members of the team, in turn, in expressing their opinions within a socially democratic atmosphere are not exercising their political control over the team leader but rather accepting the responsibility of making or helping to make certain decisions. If the team were to make too many poor decisions, the judgment of its leader and probably some of its key members would be questioned.

THE PATIENT AND DEMOCRACY

When a team works in a socially democratic way, it often tends to treat its patients in a similar way. In such instances, the patients make a great number of decisions about themselves and their treatment program which they would not expect to make under a more traditional authority structure. Here, too, it is easy to act as if some basic political rights which had been denied them previously, had been restored to them. Just as on the team, however, the proper model is a social democracy and not a political democracy. Patients are invited to participate in decisions because, to varying degrees, they are responsible enough to make valuable contributions to the process of their rehabilitation. Their participa-

tion in decisions helps them strengthen a vital human function which they will need to exercise as responsible, mature adults. The scope of their decisions can be limited on the same grounds as those applied to team members without denying the democratic ideal.

SUMMARY

This paper has argued that social democracy rather than political democracy is the proper model for the functioning of a team. Even with the acceptance of this ideal, however, at least five important considerations make impossible the attainment of the ideal in a pure form. Nonetheless, five major advantages that make attaining the ideal worthwhile are described. This discussion of the social democratic model has relevance for a clinical team's relationship toward its patients, as well as the team leader's relationship to his team.

THE COMMUNITY AS THERAPIST

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INTRODUCTION

For many years, it was possible to divide psychiatry into two broad schools, organic and psychological, although many psychiatrists have sat comfortably or uncomfortably in between, claiming such labels as "eclectic" or "multidimensional." To the two schools has been added social psychiatry, now recognized as an important force. However, as in any endeavor where there is both doubt and fervor, there is a tendency towards self-righteous denunciation of one school of psychiatry by another. The organic school has been stigmatized as "no-think," instant psychiatry, psychoanalysis described as a remunerative rationalization of sexual curiosity, and therapeutic communities ridiculed as sort of happy families of staff who are so preoccupied with their own problems that patients have to treat themselves. There is some truth in all these criticisms, especially the last, but it turns out that patients are, on the whole, rather good at treating themselves.

The term, "therapeutic community," has become so worn as to be at times almost meaningless. Some psychiatrists, reacting to the panegyrics of the uncritical who have leapt on the bandwagon to keep up with the Joneses, find its connotations not so much vague as derogatory--a half-hidden and unfair implication that communities which do not choose to adopt the label, "therapeutic," are *not* therapeutic. The real meaning of the term, however, is straightforward enough. Coined by T. F. Main in 1946, it was given flesh and blood by Maxwell Jones in his work at Belmont (later Henderson

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Hospital) in Sutton, England. Jones suggests that a therapeutic community is distinctive in the way that the total resources of an institution, those of both staff and patients, are consciously pooled in furthering treatment. In his book, *Social Psychiatry*, (6), he says,

> The social structure of a therapeutic community is characteristically different from the more traditional hospital ward...The term implies that the whole community of staff and patients is involved at least partly in treatment and administration. The extent to which this is practical or desirable will depend on many variables.

And later he adds,

> The therapeutic community approach has been criticized on the score of its vagueness, pretensions to being a specific methodology, uncritical enthusiasm which ultimately exploits the patients' credulity and so on. The fact is, of course, that there is, as yet, no one model of a therapeutic community and all that is intended is that it should mobilize the interest, skills and enthusiasms of staff and patients and give them sufficient freedom of action to create their own optimal treatment and living conditions.

There are various kinds of therapeutic communities, the characteristics of each being influenced by the type of person treated, the aims of the leader, and the attitudes of other staff and of higher authority. One community may have little in common with another, and this is as it should be. What is appropriate for the ward of a mental hospital may be out of place in a school for delinquents or a general medical unit. However, to deserve the term at all, the organization must satisfy the basic definition quoted above. Merely to label a psychiatric hospital a therapeutic community does not make it so. Attention must be given to such important matters as the freeing of communications, flattening of the authority pyramid, and shared decision-making.

Many psychiatrists are encouraged to use therapeutic community concepts by the conviction that they are in step with broad changes in society at large; for example, in education and industry. The sweeping movements of the times include considerable pressure for public enlightenment and social equality. Although medical men are conservative by training and suspicious of change, they will find it difficult (and unwise) to resist such demands. At the same time, another force is at work: the patient who feels ill, by the same token feels afraid and is quick to cast the doctor in the

role of omnipotent healer. In the past, the medical practitioner accepted this role, giving advice and making decisions as the person who knew best. The patient was expected to be passive, undemanding, and grateful--and generally he was. Doctors now stand somewhat shakily on their pedestals, and patients have come to doubt their infallibility. Some doctors have come to doubt their own infallibility and the wisdom of placing patients in a passive treatment situation. They have discovered, in fact, that many patients can give active cooperation and thus provide a very important therapeutic force. Of the medical specialties, psychiatry, being young, is perhaps more flexible and more influenced by contemporary culture. Under the influence of social scientists, psychiatrists have recognized how strongly environmental factors affect the patient for good or ill, and how interpersonal relationships are potent forces in falling ill and getting better. Therefore, although not without misgivings and disagreements, psychiatrists are reviewing their traditional methods of practice and asking other specialties to do the same.

It may be said that the social psychiatrist, while neither denying the close links psychiatry must have with the main body of medicine, nor ignoring the organic illnesses or the usefulness of drugs and physical methods of treatment, recognizes and seeks to apply the newer knowledge provided by anthropology, psychology and social studies. He constructs therapeutic communities with the object of providing a society consciously engineered for treatment and rehabilitation, where the patient's relationships with other patients, nurses, doctors, and ancillary staff are fully used in a therapeutic way. This is a great deal easier to say than to do. Basic concepts can be formulated and organized by senior staff, common goals can be set, and a working arrangement can be devised--none of these a simple matter--but putting concepts into action with staff and patients can be a demanding and stressful exercise.

GENERAL CONCEPTS AND METHODS

The Ward Meeting

An essential feature of the therapeutic community in a mental hospital is the ward, or community, meeting. Ideally, the ward meeting occurs daily and includes all patients and staff able to attend. The meeting lasts about one hour and is followed by a review meeting of staff alone. This arrangement provides, within the same framework, therapy for patients and teaching for staff. In a very real sense, both learn together.

Most psychiatrists working in this field agree that there is much to be said for using the whole ward as the treatment unit. This means that the number of patients attending a ward meeting varies from ten to thirty or more. Obviously, wards vary considerably in their long-term goals and in the intensity of their treatment measures; an acute admission unit has a different atmosphere from a long-stay ward, and different staff teams introduce different cultures. The size of the ward, and consequently the size of the group meeting, is best decided by the kind of patients being treated and the aims of the therapist. For example, in Dingleton Hospital, Melrose, Scotland, the acute-admission ward groups number some fifteen people each, while one group for long-stay patients meets around eighty strong. No one suggests for a moment that a therapist can be aware of the interactions occurring between eighty people in a room in the way he can with a small selected group. But there is great value in all patients who are living and working together meeting together. The problems they find day by day, and the methods they use to overcome or avoid them, provide the raw material for discussion and therapy.

The rules of group treatment are not easily defined; a group of itself is not necessarily a therapeutic instrument. If it has an unskilled leader and unsophisticated staff, a group may, in theory at least, be destructive rather than constructive. It is certainly true in practice that when the "ego strength" of a group is low, an individual patient may use the situation as a sounding-board for grievance or manipulate it to suit his neurotic needs. His real

difficulties lie undisturbed and unexamined, and other patients and staff may reach a stage of resentment and depression. This involves questions of leadership and the concept of permissiveness.

Much misunderstanding occurs over the nature and function of ward meetings. They are rather different from intensive group psychotherapy, although the distinction sometimes is blurred. Patients may fall into the error of thinking of a ward meeting as a sort of psychoanalysis in public, where they are examined with regard to past history and "personal problems." But the main function of the ward meeting is much more concerned with *present* difficulties and patterns of behavior. The interaction of patients with other patients and with staff, their behavior in the ward, the roles they adopt, their problems of decision-making, difficulties in work situations, and so on--these are the materials of therapy in ward meetings. It is true, nevertheless, that self-confession is a legitimate exercise in a group meeting, and some past history is necessary in order to see the patient's present behavior in perspective. It may be that therapy which goes beyond this point is best done in small, selected groups, family groups, or at individual interviews. It is likely that most psychiatrists, while encouraging full use of ward meetings, will find it necessary to provide additional therapeutic interviews, drugs, and other treatments.

Each ward meeting is followed by a staff review which carries over from the patient-staff meeting much of its atmosphere and provides an essential opportunity to examine the interactions of staff and patients. Without the review, staff do not learn to improve their performance. Even with it, learning is difficult and painful, for no one likes to be criticized, and it takes courage, initially, to comment on the behavior of one's superiors. The review, in a sense, is the staff's treatment group, where anxiety and resentment can be revealed and understood. The staff learn that the untidiness of the ward may be a form of communication from patients; that confrontation can make an aggressive outburst into a learning experience; that conduct can be examined without rancor and that responsibility shared is anxiety reduced. (Critics suggest that responsibility shared is responsibility avoided; and this can be true at times.) The review provides a multidisciplinary setting

where roles and role relationships can be examined. In a ward where a daily group meeting and review are held, training of nurses (and psychiatrists) takes on a fresh dimension.

The Patient

Whatever biological basis there is for the illness of a patient, he may be viewed as one of society's casualties because he can no longer earn his wage, live successfully with his family, or keep his friends. It is important for the patient himself to recognize this and to accept his need to modify old patterns of behavior and learn new ones. Often this is done best in a living-learning situation, which means relating to others in a group.

How far patients avail themselves of the group situation in dealing with their problems can vary enormously from patient to patient, from one group to another, and in the same patient and group from time to time. This is largely a matter of staff expectations, but it would be foolish to deny that some patients find considerable difficulty in full participation. Some people set a high value on keeping themselves to themselves and feel uncomfortable at the "open confessional" of the ward or group meeting. This may be more apparent in a hospital like Dingleton in the Borders of Scotland than, say, in London or many parts of the United States. Certainly, it seems that in the United States the instinct for privacy is weaker. Americans are characterized (so they themselves affirm) by an impulse to share their thoughts and lives which is largely foreign to the average Scot, who shows little willingness to submerge his individuality and, indeed, possesses a formidable flair for self-containment. It follows that the readiness with which group methods of treatment are taken up and exploited is largely a reflection of cultural attitudes. This is an issue which the social psychiatrist has to face squarely and sympathetically. Methods that are acceptable to a sophisticated urban population may be unwelcome and resented in a small rural community.

People tend to find what they are disposed to find. The woman who sees her neighbors as friends will find friends in the ward and feel supported and encouraged to face the task ahead. The

woman who sees her neighbors as enemies, and all strangers as threatening, will find threats and enemies in abundance upon entering a psychiatric ward. She will not experience the ward meeting as a chance to talk about herself and her difficulties, even though she needs this more than most. But one cannot shrug her off, ignore her plight, or stand aside while she discharges herself resentfully. What does one do? For the most part, reliance is placed upon the peer group. The expectation is that the example of fellow-patients will overcome her reluctance to talk and to participate. Staff may reinforce this by explanation and reassurance. Emphasis is laid upon the fact that fellow-patients are not the public at large; that many share common problems; and that a group composed of such people, together with nurses, social workers, and doctors, who have skills in understanding and helping, provides a powerful tool of therapy. If a patient finds the group meetings helpful, this overcomes fear and reticence more than anything else.

The selection of patients and their matching with the task of a group requires more investigation. There are dangers in our present method of labeling patients with traditional clinical diagnoses and pitching them into groups willy-nilly, where individual reactions may be hidden or lost. In addition, the emphasis on talking is often unsuitable for some. For the senile or long-stay patient, groups that encourage simple game-playing, music-and-movement, or work tasks, may be more appropriate. It is important, also, for therapist and patients, when they do talk, to speak the same language and to be able to communicate meaningfully. This is not always easy for the uneducated housewife, the farm laborer, or the tradesman, who may be inhibited from comment or contradiction by the therapist's verbal facility. For these reasons, it is often easier for nurses and ancillary staff to converse and relate to patients.

The Nurse

Since the nurse is in contact with the patient for so long and so closely, she is seen as a major instrument of treatment. This

requires a nurse who may or may not know a great deal of physics, biochemistry, or anatomy, but who has acquired some skills in social and interpersonal relationships. The latter are not easily taught and will certainly not be acquired in the classroom alone. But the student nurse and her teacher can find the material of learning in the life of the ward, dealing with patients who are ill, aggressive, dependent, or resistant. This is the living-learning situation, and the ward meeting is an essential part of it.

An experiment at Topeka State Hospital (2) challenges the stereotype of the mental hospital hierarchy. There, chronic female schizophrenics have been treated by psychiatric nurses as the main instrument of therapy. These nurses, who are with their patients for most of the day, take part in the patients' lives, provide a stable frame of reference, and encourage social activities and skills. Treatment is no longer seen as occurring only with the psychiatrist--the nurse-patient relationship is thought to be as important, and in many cases more important, than the doctor-patient relationship.

In a therapeutic community which extends beyond the walls of the institution to involve other health and welfare agencies and the general public, staff find new roles. For example, the nurse, because she works with the patient in the ward situation, can contribute background and knowledge when accompanying the social worker on home visits. As she develops skill and confidence, she may well lead family group meetings, in which the patient discusses his difficulties and works through them with the people most concerned. She may liase with many outside health and welfare agencies in an effort to remold the services for the mentally ill into a better-functioning whole.

It would be dishonest to report that doctors, nurses and patients take to their new relationship like ducks to water. The reactions of some patients have already been described. The nurse accustomed to a ward run on traditional lines finds in her new tasks and relationships many occasions for anxiety and resentment. Martin (8) has written of his experiences in promoting a therapeutic community at Claybury Hospital, England, and has pointed out how dependent upon authoritarian and hierarchical structure are the

nurses in a traditional mental hospital. In such a situation, efficiency may be measured by the tidiness and tranquility of the ward, with little emphasis placed upon the nurse-patient relationship. Staff relationships founded on formal rules and tacit understandings maintain status and security. If this rather rigid system is replaced by a flexible, spontaneous approach in which official status does not preclude criticism, it is easy to surmise how much upset may occur. A warm relationship between medical and nursing staff can go far in smoothing the path, but many stresses fall upon the nurse, and the psychiatrist must cultivate patience in reaching his goals.

The Doctor

Anyone who has attempted to restructure the milieu of a traditional institution knows how difficult is the task. In some ways, success depends on the size and structure of the hospital, the extent to which the psychiatrist concerned enjoys autonomy, and the warmth of his relationship with colleagues and higher authority. Organizing a therapeutic community in a small hospital is a great deal easier than in a large institution. It is arguable to what extent *one* ward of many in a large psychiatric hospital can be run on therapeutic community lines. The new ward culture, as it grows, makes an impact upon the rest of the hospital. It is unlikely that one ward or unit will be allowed quietly to evolve democratic and permissive concepts while the lives of other patients are governed by formal regulations. In these circumstances, the ward engaged in milieu therapy runs the risk of being misunderstood, resented, or even ostracized. It is a brave man who embarks on such a venture, unless he sees the spread of the new culture throughout the institution.

In his book, *Administrative Therapy*, Clark (1) discusses the history of mental hospital administration and the light cast on it in recent years by social scientists. He outlines certain principles of organization and, in particular, defines the doctor's role. It is not an easy one either to define or fulfill, and there is no universal prescription. One kind of danger is exemplified by Goffman (5) in his description of the "total institution." He emphasizes the threat

of medical dogmatism, which may be acceptable in outside society where the patient is free to reject the doctor's advice, but has unfortunate repercussions in the traditional type of psychiatric hospital where doctors' orders have the force of law. The day of autocracy--benevolent or otherwise--is largely over, but this does not mean that a modern hospital needs less in the way of leadership.

The psychiatrist, as leader of the ward team, has much to do with setting its tone and atmosphere. If he has some choice (as he should) in the appointment of nursing and ancillary staff, he will seek to have a team that balances warmth and technical efficiency. The program of the unit and how far it can be satisfied will depend a great deal on the personalities of staff, their acceptance of one another, and their ability to work together.

It is assumed here that the leader of the ward team is the psychiatrist. This is generally the case, but need not be so. Multiple or secondary leadership is certainly something worth cultivating, and nurse, psychologist, or social worker may well assume a leadership role.* However, the psychiatrist is generally the innovator and by virtue of his training and status acts as stimulator and guide toward the democratic organization that must underlie milieu therapy. It is a paradox worth recognizing that a democracy, to be efficient, needs good leadership. And this suggests a further paradox: that democracy can be maintained only from a position of power.

Democratization, permissiveness, and reality confrontation are three important concepts and guides. However, the permissiveness of a therapeutic community should not be equated with a policy of *laissez-faire*. To head such a hospital successfully demands far-reaching skills in organization and management. For example, in a crisis a leader tends to reduce anxiety by taking action, but this may result in dependency and avoidance of responsibility at lower levels. It is in such situations that experienced

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*Fort Logan has given a significant lead in demonstrating that teams can function well with nonmedical team leaders.

leadership is vital for the progress and growth of the organization.

The social organization outlined cuts across the familiar hierarchy of mental hospitals. The ward may be seen as a sort of family where worry and responsibility are shared and weaker members supported until they mature and can support themselves. This implies the acceptance of a common culture and ideology, but differences of opinion are not discouraged or repressed. For the doctor, just as for the nurse and the patient, there are stresses and demands that have to be recognized and met. It is novel for the psychiatrist in charge of a ward to be criticized by his junior colleagues, nursing staff, and patients. He must accept that statements are no longer right simply because he makes them, and his judgments and actions are open to query. For some, this is intolerable, but for those who accept that the potent influences in a hospital are exerted by the people in close contact with the patient, the inclusion of nurses and the patients themselves in the therapeutic team is an inevitability. The goal is freedom with responsibility, and to this end, the patients are given as much of both as they seem capable of handling. This is not to say that the psychiatrist abrogates his authority and the ward becomes liberal to the point of anarchy and confusion. Limits are set on behavior; the life of the ward takes place within a framework that needs to be clearly established--hopefully by consent rather than decree.

The psychiatrist running a ward as a therapeutic community faces endless daily problems that might be thought of as administrative rather than clinical. But in recent years most psychiatrists in Britain have come to accept administration and therapy as inseparable. In milieu therapy, this is not only accepted but put to positive use. The social organization is a primary treatment measure and the problems of work, feeding, recreation, and decision-making are opportunities for therapy. In the daily ward group and other meetings convened to deal with particular administrative problems, administrative and therapeutic functions are intertwined. Behavior is constantly open to analysis. This is time-consuming, particularly when the psychiatrist is not only involved with his own ward, but also with the operation of the whole hospital. At Dingleton Hospital the medical staff are all members of the Senior

Staff Committee which meets four days a week to deal with matters, particularly concerning patients, which would traditionally be the province of the Medical Director, Matron, or Manager. The S.S.C. also has a number of subcommittees that meet regularly to supervise work therapy, education, entertainment and so on. The psychiatrist therefore spends a great deal of time in meetings and groups of one sort or another. This seems slow and inefficient, and sometimes it is. The same criticism could be levelled at any democratic organization. But decisions which are group decisions, made after full consideration and discussion by those concerned or their representatives, are more likely to be accepted and put into effect wholeheartedly. In the long run, efficiency is achieved; nevertheless, so much time can be spent in shared decision-making and administrative entanglements that the main medical and clinical function of the hospital and of the doctor is threatened. Meeting may follow meeting and involve so much time that the balance of the psychiatrist's day is upset. There may be moments when he feels it is all talk and no treatment. Actual clinical time becomes scarce and the individual patient runs the risk of neglect. However, if a social structure demands this sort of attention it *is* inefficient and in need of overhaul.

The crisis bringing the patient to the hospital is often precipitated by a breakdown of family resources. This is most apparent at the time of admission, when the family can be seen together and the relevant factors assessed. Such assessment clarifies, for the treatment team and for the family itself, what events and relationships have led to breakdown and what can be done about it. Family group therapy can then proceed with hope of consensus regarding "treatment," which may well involve other members of the family besides the patient in a review of roles and interactions. Often more rewarding than either ward meeting or individual interview is the coming together of a family to work through the problems that brought the patient into the hospital. The family is frequently a more fruitful unit for therapy than the individual patient.

It is reputed that Mr. Nubar Gulbenkian considers the best dinner parties to consist of two people--himself and the head waiter.

There are patients who echo this sentiment in relation to psychiatric treatment. They demand and seem to benefit from a one-to-one relationship with the therapist. Occasionally, a patient resents the group situation so fiercely that he will make no real use of it at all. Like a sick child, he seeks the assurance of parent-doctor, and it may be pointless and even dangerous to deny the need. Should the psychiatrist refuse, a nurse or fellow-patient may be forced to adopt the role--and be much less expert at it.

It is probable that most psychiatrists using therapeutic community methods, while firmly believing that social structure itself can be a primary treatment measure of great importance, still find it necessary to rely on other therapies. Ward meetings tend to look particularly at the "here-and-now;" some patients are reluctant to make full use of groups; pressure on the doctor may come from relatives or employers; the spectrum of patients admitted to a psychiatric hospital is wide and all do not fit readily into a neat treatment pattern. For these reasons and others, the psychiatrist may use alternative measures such as individual psychotherapy, drugs, and E.C.T. In such circumstances, this is wise, for it is pointless (in an exclusive commitment to milieu therapy) to deny patients medicaments merely to bemuse them with pseudo-events. Each psychiatrist finds for himself the balance between group methods and other therapies that satisfies his patients, himself, and his staff. It is a balance that changes constantly and the label, "trick cyclist," may not be inappropriate for the doctor who is trying to progress in such circumstances.

As already suggested, there may be considerable differences from one ward to another, e.g. in the use of physical treatments, individual interviews, small psychotherapeutic groups, and the amount of responsibility given to patients. Inevitably, however, the psychiatrist is forced to re-examine many cherished ideas and accept fresh methods. He finds that some of the functions traditionally reserved for the doctor are better performed by another member of the team or by a whole group. On the other hand, he may find himself in unfamiliar situations; in work programs with patients, he will discover that work provides a real opportunity for "living-learning." The therapeutic opportunities must be

grasped, however, and work not used merely as a time-filler or a service to the hospital. (10)

The psychiatrist finds himself not only outside his office, but also outside ward and hospital, dealing with employers, shopkeepers, public health workers, school teachers, and law enforcement agents. This is good, since social psychiatry aims to leave behind the concept of treatment as a hospital function and prefers to set the patient back in the community as soon as possible with the active help of those concerned. Since hospital stay is but one phase of treatment, staff and patients must often forsake their accustomed roles and move into the outside community to achieve rehabilitation and resettlement.

TREATMENT CONCEPTS

Until recently, the treatment of the mentally ill in hospitals was seen in terms of individual psychopathology. Drugs, physical methods, and the doctor-patient relationship constituted the therapeutic attack. The hospital's social structure and the daily interactions that weave the fabric of the patient's life received scant attention. This situation has changed considerably and great interest is now being shown in the dynamic relationships between ego and milieu. It is appreciated that the patient's stay in a hospital is not, as Levinson and Gallagher (7) point out, merely an opportunity for the "illness" to receive "treatment," but is a forceful encounter between the patient's personality on the one hand and the hospital's social organization on the other. Recognition of this has led to a re-examination of ideas which the psychiatrist has long held dear--the supreme importance of the doctor-patient relationship, confidentiality, and much else that belongs to the medical model of illness. The person who is emotionally disturbed or psychiatrically ill may not, in fact, have an underlying pathological process which has a specific etiology, treatment, and course. Indeed this framework may be inappropriate for the understanding and treatment of those who have problems in living. Believing this to be so, many psychiatrists have set out to use the

social organization of the ward or hospital as a primary treatment measure. They have evolved therapeutic communities.

One supposes that every patient who enters a hospital does so with hopes and fears of what awaits him. He sees himself playing a certain role in relation to other patients and particularly to staff, who themselves have definite role-conceptions. It is clear from experience that what patients and staff believe the other person should be doing is far from uniform; consequently, a ward may encompass a number of separate worlds. A patient may demand treatment in a form that is neither appropriate nor available. Doctor and nurse may assume mistakenly that their goal in treatment is shared by the patient and his relatives. Any attempt to break down these barriers and open adequate channels of communication must be of benefit and release considerable therapeutic potential. Yet it is more difficult than it sounds. Both staff and patients cling tenaciously to their traditional roles. It is necessary for all concerned to learn new patterns of behavior and this is stressful. Is all this worthwhile? What are the benefits? And can therapeutic community methods be shown to be superior to those that are more traditional?

It is plain that those of us who practice therapeutic community methods believe that they have considerable advantages. What has already been discussed indicates the general basis of such a belief, but firm evaluation--as in other types of psychiatric treatment--has proved difficult. Aware of the need for a set of concepts to embrace the interactions of personality and environment, Cumming and Cumming (3) attempted to meet it in a study which is a landmark in social psychiatry. They brought together accepted psychological and sociological concepts and constructed a theory of function and dysfunction in relation to milieu. They went on from this to suggest how a therapeutic community works or fails to work. In Massachusetts, Levinson and Gallagher conducted a sophisticated research inquiry into "patienthood" in a therapeutic community. Their considerations of the hospital's social structure, the patient's conception of his role, the influence of his social class, etc., revealed areas of great significance. Few firm conclusions were drawn, although a vista of research possibilities

using similar methods was opened up. In a painstaking and comprehensive study in Palo Alto, Fairweather and his colleagues (4) compared the effects of the community methods of one ward with the more traditional regime of another in the same V.A. hospital. A vast amount of data was accumulated and analyzed, but the results proved disappointing. Successful post-hospital adjustment was shown to be only slightly related to adaptive social behavior demonstrated in the hospital itself and largely unrelated to attitudes, perceptions, and expectations expressed during treatment. The investigators concluded sadly that a hospital community cannot successfully duplicate the outside situation.* Studies of this sort, therefore, fail to show a convincing superiority in the results of therapeutic community methods over other treatment methods.

In a way, this may not be a bad thing for psychiatry and the future of milieu therapy. Nothing brings an idea into quicker disrepute than its exploitation in a half-understood and inappropriate fashion. Therapeutic community methods, like most new fashions, attract extremists who may be seduced by their own propaganda into believing that they are vouchsafed a greater awareness of truth and progress than others. This may be dangerous. Psychiatry, like other departments of medicine and life, has its ephemeral enthusiasms. Indeed, they give spice and motivation. But true therapy, like true art, sloughs off extravagances while incorporating the worthwhile that is new. There is a risk in valuing the new above all, discarding older methods not because they are inferior but because they are old. An awareness of the limitations of one's methods may be humbling and even inhibiting, but it is a vital part of the psychiatrist's knowledge.

Critics of therapeutic communities argue, and Fairweather's investigations just referred to, suggest that the culture of the hospital community is artificial and does not help the patient to

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*However, further development of patient task groups at Palo Alto led to the setting up of a community lodge. The lodge project has shown promising results.

cope with real life problems outside the hospital. It can only be said in support of the methods of therapeutic communities that great emphasis is laid upon the need to relate the patient's family and outside life to his treatment in the hospital. A well-developed system of milieu therapy gives the patient an opportunity to learn or rediscover his roles in an atmosphere as near real life as possible. Day by day he is encouraged to meet and solve problems that are relevant and by so doing develop his ego in its organization, identity, and strength. A community which sets out to do this must embrace permissiveness as a basic concept.

Permissiveness

Permissiveness is perhaps *the* guiding principle of therapeutic communities. It overlaps other important areas of concern such as leadership, authority, responsibility, decision-making, confrontation, role-finding and the relationship of hospital culture with that of the outside world. Despite its central importance, the concept of permissiveness is frequently misunderstood and misapplied.

Permissiveness means the toleration of deviant behavior and the willingness to accept actions that are normally unacceptable. The behavior is tolerated, however, with a definite object in view--its examination by all concerned. Instead of suppressing deviant behavior or sweeping it out of sight by regulation, its expression is allowed in the hope that causes will be uncovered and control achieved. There is, therefore, a sparing use of restrictions and sanctions. These are indispensable, but take their force from the norms of the whole group. Patients are expected to accept responsibility for themselves and for the group of which they are members, but responsibility is matched with capability. What a patient cannot do for himself, other patients or staff will try to do for him. What he *is* capable of doing is expected of him and, if "freedom with responsibility" is abused, the facts are examined in face-to-face discussion. By this confrontation it is hoped the patient learns his role and is helped to alter patterns of behavior that have led to trouble and difficulty.

The application of this principle calls for experience and skill and is not without its dangers. If permissiveness is mistakenly equated with lack of leadership or absence of limits, chaos and frustration result. Junior staff, both nursing and medical, may find difficulty in the beginning in retaining self-confidence and the ability to accept responsibility when they feel that the rule-book has been torn up. In a way, it is much easier to have rules and regulations that, when broken, carry their statutory penalties. To take each case as it comes, making full use of confrontation in crises, and suiting decisions to circumstances, is more trouble and more stressful to staff and patients. This does not mean that rules and punishment are discarded. It does mean that opportunities are grasped to analyse situations so that all may learn and insight and growth may be encouraged.

Rapoport (11) discusses the fluctuations in a social organization (a process he calls "oscillation") and points out how a given situation may be handled differently according to the "emotional climate" of the unit. There is constant interplay between forces of deviancy and disorganization on the one hand and those of authority and reparation on the other. On the whole, however, the literature on group methods of treatment is strangely silent about the less welcome aspects of permissiveness. It is well to remember that to treat patients permissively is to invite behavior designed to avoid responsibility and test limits. (9)

Permissiveness is not the same as passivity. Leadership is necessary at many levels. Indeed, the democratic form of administration that is so important a part of the therapeutic community ideal implies a growing-up of many leaders among staff and patient populations. Until nurses, junior doctors, and others who by custom occupy a lowly place in the hierarchy, gain enough confidence and knowledge to voice criticism and take an active part in decision-making, the system is not in full play. It is, after all, the essence of democracy that government is inconvenienced, harassed, questioned and changed. The correct use of leadership or authority is not easy to describe or enact. Cumming and Cumming (3) discuss such difficulties and point out how important are open communications in ensuring a reasonable authority structure. In ordinary life,

the abuse or withholding of information are common tactics in the control of a situation. But, in a therapeutic community, such behavior impairs working relationships and destroys any pretense at democratic decision-making. Certainly in this sense it is true that it takes an informed people to make a free choice.

It is expected that any social system which adopts a permissive orientation will grow by a process of self-education to a mature level. People learn to distinguish permissiveness from indifference; they find it is not an excuse for avoiding responsibility; and they start to meet problems more constructively and intelligently. But no society is ever ideal. There are always those who will not or cannot learn. This circumstance forces those in authority to set limits on behavior while seeking always to continue the educative process for which therapy is another name.

The Community Outside

Although the term therapeutic community is generally applied to an institution, it has equal relevance to the extramural dimension of treatment. More and more, the wall that separates the psychiatric hospital from the outside community is being destroyed and fresh sources of help are discovered. As the artificial separation between the "inside" and "outside" communities disappears, surely the leap from patienthood back to family, work and friends will be taken with less stress and greater support.

Unfortunately, in one or two areas, the term "community care" has become almost a rude expression. Relatives found that it signified an infrequent out-patient appointment or casual visit from a social worker. A family which feels bewildered and almost abandoned in its responsibility for a psychotic member is not likely to provide a therapeutic situation. On the other hand, where true community care is practiced, where local mental health services, family doctor, voluntary agencies, and the hospital are knit into a competent organization for the benefit of the patient, great advantages can be claimed. Such a system not only finds the treatable case early, but also brings him into the optimal treatment situation. It provides an opportunity for those concerned to discuss and

decide, gives information and suitable facilities, and enhances a rational disposal and follow-up policy. The hospital takes its proper place in treatment. The patient's stay may often be a short episode in the program of therapy, or a hospital stay may be entirely avoided in favor of day care or some other alternative. It is against such a background that the psychiatric hospital practicing therapeutic community methods comes into its own. The culture makes it comparatively easy for "outside workers" (e.g. public health nurses, family doctors, and voluntary agencies) to find a welcome and a role; and everyone's performance is better defined and improved in such a living-learning situation.

These considerations perhaps go some way in answering a further criticism of therapeutic communities: that little influence can be exerted upon a patient's personality by such methods in the short term. I think it is true that in the mental hospital it is easier to demonstrate change in the long-term population and see fairly convincing evidence of altered behavior patterns in response to the pressures of milieu therapy. In the admission wards the situation is rather different, and it is legitimate to ask what the therapeutic community offers to the patient who is hospitalized for a month or two only, anxious for prompt return to a productive life in the community outside. The treatment goal is not fundamental change in personality. Rather, it is examination of interpersonal relationships and consequent improvement in social adjustment. But here again, treatment goes beyond the understanding of individual difficulties and adaptation within the ward groupings; it includes examination of family patterns of behavior and how obligations in the outside world are met or avoided. For these reasons therapy emphasizes socio-adaptive goals and the integrated aspects of the patient's personality, rather than the achievement of individual insight.

Appraisal

At Dingleton Hospital, we recently found a small pilot study of patient attitudes in the male and female admission wards enlightening. Twenty patients, who had been in the hospital for at

least several weeks, were asked to complete a questionnaire. It posed questions like: "Who do you feel is most willing to help you?", "Who decides when you will leave the hospital?", "Whom do you talk to most often about your problems?". Even with such a simple investigation, the answers proved difficult to analyze and understand. Conflicting answers were given sometimes by patients in attempts to define their attitudes toward responsibility, communication, staff availability and so on. However, on the whole, it did appear that patients accept that they themselves have an important and active part to play in their own treatment and that of others. Also, they made use of the expanded roles of nursing staff, turning frequently to a nurse when before they would have demanded a doctor. Although there were reservations about ward meetings--the ease of communicating in them and the value of the help given--they were found to play a role in treatment equal to that of individual doctor or nursing staff. Both patients and staff are now finding family group therapy the most rewarding of all.

An important criticism has been expressed that, while in the past psychiatry treated the patient too much as an individual apart from his environment, in the therapeutic community we risk losing the individual in the group. Conformity with hospital culture becomes synonymous with good adjustment and yet the patient's individual difficulties are ignored. Just as public life drives out private life, the more collective a society becomes, the more individuality is threatened. In this fashion, there may arrive a situation when the purpose of a group takes precedence and individual needs are submerged.

The prevailing view in any society should not have the force of sanctity. It is wrong for anyone, staff member or patient, who lacks enthusiasm for a desired course of action, to be labelled a security risk. The nonconformist must be allowed to exist. It is necessary to be aware of such dangers in a therapeutic community in a psychiatric hospital, a system that upholds governing principles and expects them to be honored. But the concepts which support the therapeutic community are liberal, and the democratic nature of the organization provides many safeguards for the individual and opportunities for him to be heard. In this way the

system protects itself from danger at either extreme: on the one hand, that an eccentric wild-eyed leader will plunge the community into chaos; or, on the other, that undue emphasis on egalitarianism will cause a mediocrity inimical to the true interests of the community. Wise and energetic leadership is necessary, but the social structure has built-in safety factors in its efficient communication network and its mechanisms of feedback and confrontation. The habit and style of a therapeutic community is one of debate and experimentalism; these are geared not to the elaboration or proving of pet theories, but rather to the needs of patients. The culture must maintain a great sensitivity to the values of the community it serves and always be prepared to modify its clinical and administrative methods in the face of legitimate pressures.

Since our patients do not seem to fall ill for particularly logical reasons, it may be foolish for psychiatrists to become obsessed with an overly scientific attitude. The emphasis on conscious goals and rational methods may lead to neglect of unknown realities. This is not to deny the need for precise knowledge and a refined therapy. It is likely, for example, that an application of learning theory to the methods of milieu therapy and group techniques would be illuminating; this might provide clearer goals for the psychiatrist who all too often enters the treatment situation with a hodge-podge of assorted psychoanalytic concepts, mixed with clinical acumen and therapeutic zeal. The plea is rather for wise compromise and an acceptance of where we stand at present. In the world of ideas, penetrating comment can come from the mentally disturbed. Doctors know a great deal, but there is much they do not know. Psychiatry in particular, dealing with conditions of puzzling etiology and with few specifics for treatment, must retain humility and openmindedness. Behind our impressive jargon and mystical methods lies immense ignorance. We should not be ashamed to let our patients help themselves and join with us—doctors, nurses, social workers and others—in a partnership that is therapeutic.

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The Fort Logan Mental Health Center is Colorado's second state hospital. Currently serving almost half the population of the state, its organization follows as much as possible the recommendations of the Joint Commission on Mental Illness and Health. Concepts of milieu therapy are strongly utilized, with emphasis on expansion of professional roles and the involvement of the patient's family and his community in treatment. The hospital is entirely open and relies heavily on transitional forms of treatment. Approximately one-half of its patients are admitted directly to day care, and evening care is offered. Geographic and administrative decentralization are utilized, with the same psychiatric team following the patient from the time of admission through all phases of treatment.